Montana's Healthcare Programs NPI Enrollment

(for participation after September 30, 2007)

Thank you for choosing to enroll as a Montana Medicaid, CHIP Dental or Extended Mental Health and/or MHSP provider. All applicable sections of the provider enrollment form must be completed in order for us to process your application. The 4-digit ZIP code extension is required on all addresses. **Incomplete applications will not be processed.**

Complete all sections of this application unless otherwise indicated. Original signatures are required. Copied or stamped signatures are not acceptable.

Sign and return this application along with any additional required documents to:

Montana Provider Relations
P.O. Box 4936
Helena, MT 59604

Your application will not be processed until this information is received via mail.

PASSPORT reenrollment is ***not*** required.

Clinics and groups may now enroll in Montana's Healthcare Programs. Rendering providers are required to be enrolled and indicated on the claim. Individuals must only enroll one time, regardless of the number of locations in which they practice, with the exception of enrolling to provide waiver services. Participation in the waiver program requires separate enrollment.

If you have any questions regarding information required on the enrollment application, you may contact Provider Relations by calling 1-800-624-3958 or 406-442-1837 or sending an e-mail to mtprhelpdesk@acs-inc.com. Applicants who wish to change information on a submitted application or for an existing provider must contact Provider Relations directly.

Health care providers participating on and after October 1, 2007, must obtain and use a National Provider Identifier (NPI) for all transactions and claims. This requirement applies to all transactions and claims received on and after October 1, 2007. This is a federal mandate. More information is available at www.cms.gov. Do not bill using your National Provider Identifier (NPI) number until October 1, 2007.

Montana Medicaid, CHIP, and MHSP Enrollment Checklist

For your convenience, we are providing a checklist to ensure that your provider enrollment form is completed correctly. The following information must be reviewed, signed, and dated as applicable.

All Medicaid-Only Providers

_____ 1. Read and sign the Montana Medicaid Provider Enrollment Signature Page. If the application is for an individual, the individual who will be providing the service must sign it. If the application is for an organization, an individual authorized to enter the organization into a legal contract must sign it. It must be signed by all who are required to sign it.
_____ 2. Complete, sign and date the printed W-9.
_____ 3. Complete and sign the Direct Deposit Sign-Up Form (Standard Form 1199A). **This is optional for out-of-state providers.**
_____ 4. Include a signed letter of hardship if requesting payment via paper check (if applicable).
_____ 5. Attach a **photocopy of your current license** showing an effective and expiration date. If you are enrolling to bill for services already provided, also enclose a photocopy of your license covering that date of service.
_____ 6. Attach a **photocopy of your applicable board certification.**
_____ 7. Attach a **photocopy of your National Provider Identifier (NPI) designation letter or e-mail** from the National Plan and Provider Enumeration System (NPPES)
_____ 8. Sign the printed Trading Partner Agreement to enable access to the Montana Access to Health web portal.
_____ 9. Include a letter of termination if you are changing ownership or your tax ID. These changes require you to terminate your old provider number and apply for a new provider number. The termination letter needs to contain the following information: the provider number to be terminated, the termination date, and the effective date of the new provider number. The termination date of your previous number must be after any dates of service for which claims were billed utilizing that provider number.
_____ 10. Include a copy of the organization's form IRS-P575 or, if not available, the W-9 (if ownership or control interest of 5 percent or more in other organizations that bill for publicly funded health care programs).
_____ 11. If you bill laboratory services, you must enclosed a copy of your CLIA certification.
_____ 12. Include your CMS Provider-Based Facility Designation (if applicable).

Medicaid Pharmacy Providers Only

_____10. If you are enrolling due to a change in ownership or tax ID change and you assume the former provider's NABP number, you must indicate an effective date after the termination date for the previous provider.

Medicaid and CHIP Providers (Dental or Extended Mental Health Only)

In addition to the above Medicaid-only requirements:

_____ 1. Read and sign the CHIP Dental Provider Enrollment Signature Page. If the application is for an individual, the individual who will be providing the service must sign it. If the application is for an organization, an individual authorized to enter the organization into a legal contract must sign it.
_____ 2. Read and sign the CHIP Extended Mental Health Benefit Enrollment Signature Page. If the application is for an individual, the individual who will provide the service must sign it. If the application is for an organization, an individual authorized to enter the organization into a legal contract must sign it.

CHIP-Dental Providers

In addition to the above Medicaid-only requirements:

_____ 1. Read and sign the CHIP Provider Enrollment Signature Page. If the application is for an individual, the individual who will be providing the service must sign it. If the application is for an organization, an individual authorized to enter the organization into a legal contract must sign it.

Completing and signing the printed Direct Deposit Sign-Up Form (Standard Form 1199A) is optional for CHIP providers.

You do not need to read and sign the Montana Medicaid Provider Enrollment Signature Page.

MHSP Providers

In addition to the above Medicaid-only requirements:

_____ 1. Read and sign the Mental Health Services Plan Provider Enrollment Addendum.

School-Based Services Providers

In addition to the above Medicaid-only requirements:

_____ 1. Completing and signing the printed Direct Deposit Sign-Up Form (Standard Form 1199A) is optional for school-based services providers.

_____ 2. If the school is enrolling for a CSCT provider number, the Comprehensive School and Community Treatment Contract must be signed and dated by both the school and the mental health center the school is contracting with. The contract language included in this package is boilerplate and may be changed per the needs of the school and the mental health center.

Montana's Healthcare Programs NPI Enrollment Application

PROVIDER TYPE

Please enter your provider type from the following list: _____

Ambulance
Ambulatory Surgical Center
Audiologist
Birthing Center
Case Management - Mental Health
Case Management - Non-Mental Health
Certified Nurse Specialist
Chiropractor
Clinic - Podiatry
Clinic - Physical Therapy
Clinic - Dental
Clinic - Physician
Clinic - Chemical Dependency
Clinic - Freestanding Dialysis
Clinic - Rural Health
Clinic - Federally Qualified Health Center
Clinic - Public Health
Clinic - Clinic/Group Not Otherwise Specified
Dental
Denturist
Durable Medical Equipment
Eyeglasses Contractor
Eyeglasses Contractor (CHIP)
Hearing Aid Dispenser
Home and Community Based Services
Home Dialysis Attendant
Home Health Agency
Home Infusion Therapy
Hospice
Hospital - Inpatient
Hospital - Swing Bed
Independent Diagnostic Testing Facility (IDTF)
Indian Health Services (IHS)
Intermediate Care Facility - Mentally Retarded
Laboratory
Licensed Professional Counselor
Mental Health Center
Nurse Midwife
Nurse Practitioner
Nursing Home
Nutritionist / Dietician
Occupational Therapist
Optician
Optometrist
Personal Care Agency
Pharmacist
Pharmacy
Physical Therapist
Physician
Physician Assistant
Podiatrist
Private Duty Nursing Agency
Psychiatrist
Psychologist
Registered Nurse Anesthetist
Residential Treatment Center
Respiratory Therapy (EPSDT)
School
Skilled Nursing Facility/ Intermediate Care Facility - Mental Aged
Social Worker
Speech Pathologist
Taxi
Therapeutic Group Home
Transportation - Non-emergency

Targeted Case Management providers only: If you selected Targeted Case Management as your provider type, what type of services do you wish to provide?

_____ TCM Pregnant Women
_____ TCM Developmental Disability
_____ TCM Children at Risk
_____ Children With Special Healthcare Needs
_____ TCM Mental Health

School-Based Services providers only: If you selected School-Based Services as your provider type, select the type of School-Based Services you are enrolling for:

_____ Individualized Education Plan (IEP) Services
_____ Comprehensive School and Community Treatment (CSCT) Team Services
(If CSCT, select the team number you are enrolling)

_____ TEAM 01
_____ TEAM 02
_____ TEAM 03
_____ TEAM 04
_____ TEAM 05
_____ TEAM 06
_____ TEAM 07
_____ TEAM 08
_____ TEAM 09

CONTINUED ON NEXT PAGE

PROVIDER TYPE (continued)

Out-of-state hospitals only: If you are an out-of-state hospital and would like to be considered a "Preferred Out-of-State Hospital," please contact the Hospital Case Manager at (406) 444-0061, P.O. Box 202951, Helena, MT 59620-2951 for instructions.

Would you like to be considered a "Preferred Out-of-State Hospital"? _____ Yes _____ No

Note: A Preferred Out-of-State Hospital is a hospital located more than 100 miles outside the border of Montana that has signed an agreement with the Department to provide specialized services that are prior approved by the Department or our designated utilization review organization. By agreeing to become a "Preferred Hospital," the facility will be reimbursed hospital-specific cost-to-charge ratios that will be cost settled annually. Reimbursement without authorization will be reimbursed at the in-state Diagnosis-Related Group (DRG) payment rates and will not be eligible for cost settlement. Out-of-state hospitals not signing a preferred hospital agreement will receive in-state DRG reimbursement that will not be eligible for cost settlement. These services will not require prior authorization.

Clinics only: Clinics and group may now enroll in Montana's Healthcare Programs. Each clinic location must be enrolled separately. If you are enrolling any of the clinic types listed below, please ensure that you complete a separate application for each clinic location you wish to participate within. Rendering providers must also enroll separately.

Clinic - Podiatry
Clinic - Physical Therapy
Clinic - Dental
Clinic - Physician
Clinic - Clinic/Group Not Otherwise Specified

Individuals must only reenroll once, regardless of the number of locations in which they practice or the number of Medicaid provider numbers they currently have, with the exception of enrolling to provide waiver services as participation in the waiver program requires separate enrollment. Individuals will no longer be required to be the billing provider on claims. Clinics and groups are now permitted to enroll and may be the billing provider on the claim. Effective May 23, 2007, individuals will not be enrolled multiple times for multiple locations in which they practice.

TAXONOMY CODES

Please select up to three from the chart in the Application Supplemental Information:

_____ _____ _____

PROGRAM TO ENROLL IN

You may enroll as a Medicaid provider, CHIP provider, or both:

_____ Medicaid only
_____ Children's Health Insurance Program (CHIP) only (dental providers only)
_____ Both Medicaid and CHIP (dental providers only)

NATIONAL PROVIDER IDENTIFIER

Enter your 10-digit National Provider Identifier (NPI) number: _____
If you are a healthcare provider, this is required. If you are a healthcare provider and do not have an NPI, you must obtain one from www.nppes.cms.hhs.gov before you complete your enrollment.

If you are an atypical provider, you might not have an NPI. If not, check here and we will assign you a new provider number.
I am an atypical provider and I do not have an NPI:_____

NAME

If enrolling as an individual:
Last Name: _____ First Name: _____ M.I.: ____
Title: _____ Miss _____ Mrs. _____ Mr. _____Ms.
Professional Title: _____

If enrolling as an organization:
Organization Name: _____

PHYSICAL OR PRACTICE ADDRESS / CONTACT INFORMATION

Address: _____ (P.O. Boxes are not acceptable)
Address Line 2: _____ (P.O. Boxes are not acceptable)
City: _____ State: _____ ZIP_____ - _____
County (only required for in-state providers): _____
Telephone Number: _____ Ext.: _____
Administrative Fax: _____ Ext.: _____

LENGTH OF ENROLLMENT

If physical or practice address is in any state other than Montana, enter desired length of enrollment.
Desired Enrollment Period (enrollment period will begin on the date of submission):
_____ 1 month
_____ 3 months
_____ 6 months
_____ Specific dates of service
_____ Indefinite

Specific Dates: From ___/___/_____ to ___/___/_____
Note: The "to" date is only required if "Specific Dates of Service" is selected as the Desired Enrollment Period.

PAY TO ADDRESS

Would you like to direct your Remittance Advice to an address other than your practice address?
_____ Yes _____ No
If yes, enter your Pay To address:
Address _____
Address Line 2_____
City: _____ State: _____ ZIP_____ - _____
County (only required for in-state providers): _____

CORRESPONDENCE ADDRESS

Do you want to direct your provider correspondence to an address other than the practice or pay to address? If yes, enter correspondence address:
Address _____
Address Line 2_____
City: _____ State: _____ ZIP_____ - _____
County (only required for in-state providers): _____

CONTACT E-MAIL ADDRESSES

Note: You must enter at least one, and may add up to five, contact e-mail addresses.

E-mail Type: _____ Technical
_____ Practice
_____ Business
_____ Financial
_____ Clinical
_____ Other
E-mail Address: _____

E-mail Type: _____ Technical
_____ Practice
_____ Business
_____ Financial
_____ Clinical
_____ Other
E-mail Address: _____

E-mail Type: _____ Technical
_____ Practice
_____ Business
_____ Financial
_____ Clinical
_____ Other
E-mail Address: _____

E-mail Type: _____ Technical
_____ Practice
_____ Business
_____ Financial
_____ Clinical
_____ Other
E-mail Address: _____

E-mail Type: _____ Technical
_____ Practice
_____ Business
_____ Financial
_____ Clinical
_____ Other
E-mail Address: _____

MOST CURRENT PROFESSIONAL LICENSE INFORMATION

License Number: _____ State: _____
Effective Date: ___/___/_____ Expiration Date: ___/___/_____
Note: An expiration date is only required for out-of-state license.

BOARD CERTIFICATION

Are you board certified? _____ Yes _____ No
If yes, what is your certification type?
_____ State license
_____ County/City license
_____ Other
Certification Date: ___/___/_____ Certification Number: _____

OWNERSHIP TYPE

Enter your type of ownership:

_____ Individual
_____ Partnership
_____ Corporation
_____ Hospital-Based
_____ Group
_____ Clinic
_____ Other

PROVIDER-BASED FACILITIES

Montana Medicaid only recognizes Provider-Based Facilities that have received official designation from the Centers for Medicare and Medicaid Services (CMS). Have you been designated by CMS as a "Provider-Based Facility"? _____ Yes _____ No
If yes, include your CMS designation letter with your enrollment paperwork.

TAX REPORTING STATUS

Tax Reporting Status: _____ Individual _____Organization

INDIVIDUAL FILING INFORMATION

Enter the name and Social Security number of the individual for which this application is being filed. The name must match the name on file with the IRS exactly. This is the entity to which payments will be made when the enrolling provider is the **billing** provider on the claim.
Last Name: _____ First Name: _____ M.I.: ____
Social Security Number: _____

The U.S. Department of Human Services, Office of Civil Rights is requesting the following information be completed for statistical purposes only. This information is optional and is not required for Montana Medicaid.
Gender: _____ Male _____ Female
Race: _____ Asian or Asian American or Pacific Islander
_____ Hispanic
_____ White (not Hispanic)
_____ Black (not Hispanic) or African-American
_____ North American Indian or Alaska native

BUSINESS FILING INFORMATION

Enter the name and Federal Employer Identification Number (FEIN) or Employer Identification Number (EIN) of the business for which this application is being filed. The name must match the name on file with the IRS exactly. This is the entity to which payments will be made when the enrolling provider is the **billing** provider on the claim.

Organization Name: _____
FEIN/EIN: _____

OWNERSHIP/CONTROL INFORMATION

This section must be completed for each person who has an ownership or controlling interest in the provider entity specified in this enrollment application.

A person with an ownership or control interest is defined as a person that (a) has an ownership interest totaling 5% or more; (b) has an indirect ownership interest equal to 5% or more; (c) has a combination of direct and indirect ownership interests equal to 5% or more; (d) owns an interest of 5% or more in any mortgage, deed of trust note or other obligation secured by the provider if that interest equals at least 5% of the property or assets of the provider; (e) is an officer or director of a provider that is organized as a corporation; or (f) is a general or limited partner in a provider that is organized as a partnership or limited partnership.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Note: At least one person must be, and up to 24 persons can be, added. Please enter additional owners on a separate page.

Ownership: _____ Owner _____ Managing Employee
Last Name: _____ First Name: _____ M.I.: ____
Date of Birth ___/___/_____ Social Security Number: _____
Country of Birth: _____
State of Birth (only required if country of birth is U.S.): _____
County of Birth (only required if country of birth is U.S.) _____
MT Provider # (enter the owner's or managing employee's most recent provider number, if applicable):
_____

Are you the spouse, parent or sibling of a person with ownership or control interest?
_____ Yes _____ No
If yes, enter name and relationship.
Name: _____
Relationship _____ Spouse
_____ Parent
_____ Child
_____ Sibling

Have you ever been sanctioned, debarred, suspended, excluded or convicted of a criminal offense related to Medicare/Medicaid or any other State or Federal program?
_____ Yes _____ No
If yes, enter explanation: _____
_____
_____

OWNERSHIP ORGANIZATION INFORMATION

Do you have ownership or control interest of 5 percent or more in another organization that bills for publicly funded health care programs? _____ Yes _____ No
Note: Up to four organizations can be added.
Legal Business Name: _____Employer ID: _____
Legal Business Name: _____Employer ID: _____
Legal Business Name: _____Employer ID: _____
Legal Business Name: _____Employer ID: _____

SUBSIDIARY OR JOINT VENTURE BUSINESS INFORMATION

Is your organization a subsidiary company or joint venture? _____ Yes _____ No
Note: Up to four organizations can be added.
Legal Business Name: ______________________________Employer ID: ___________
Provider Number:_________________________
Address ____
Address Line 2____
City: ______________________________ State: ________ ZIP______________ - ______
County (only required for in-state providers): ____________________________
Telephone Number _________________________ Ext: ________
Administrative Fax _________________________ Ext.: ________

Legal Business Name: ______________________________Employer ID: ___________
Provider Number:_________________________
Address ____
Address Line 2____
City: ______________________________ State: ________ ZIP______________ - ______
County (only required for in-state providers): ____________________________
Telephone Number _________________________ Ext: ________
Administrative Fax _________________________ Ext.: ________

Legal Business Name: ______________________________Employer ID: ___________
Provider Number:_________________________
Address ____
Address Line 2____
City: ______________________________ State: ________ ZIP______________ - ______
County (only required for in-state providers): ____________________________
Telephone Number _________________________ Ext: ________
Administrative Fax _________________________ Ext.: ________

Legal Business Name: ______________________________Employer ID: ___________
Provider Number:_________________________
Address ____
Address Line 2____
City: ______________________________ State: ________ ZIP______________ - ______
County (only required for in-state providers): ____________________________
Telephone Number _________________________ Ext: ________
Administrative Fax _________________________ Ext.: ________

PREVIOUS PROVIDER NUMBER(S)

Have you previously billed Montana Medicaid, CHIP or MHSP? _____ Yes _____ No
Note: In cases of reenrollment, it is critical that you provide accurate information so we may set up your new enrollment consistently with your previous enrollment. Up to four provider numbers can be added. Please enter all that apply to the enrolling provider type.
Provider #: ____________
Begin Date: ___/___/_____ End Date: ___/___/_____
Provider #: ____________
Begin Date: ___/___/_____ End Date: ___/___/_____
Provider #: ____________
Begin Date: ___/___/_____ End Date: ___/___/_____
Provider #: ____________
Begin Date: ___/___/_____ End Date: ___/___/_____

PREVIOUS TAX ID

Have you changed or ever used another Tax ID number? _____ Yes _____ No
Note: Up to four tax IDs can be entered.

Tax ID #: _____ Tax ID #: _____
Begin Date: ___/___/_____ End Date: ___/___/_____ Begin Date: ___/___/_____ End Date: ___/___/_____
Tax ID #: _____ Tax ID #: _____
Begin Date: ___/___/_____ End Date: ___/___/_____ Begin Date: ___/___/_____ End Date: ___/___/_____

CLIENT DEMOGRAPHICS

Number of clients currently being seen (Montana Medicaid clients only): _____
Gender of clients: _____ Male _____ Female _____ Both

EARLIEST DATE OF SERVICE

Have you already provided services to a Montana Medicaid, CHIP, or MHSP client?
_____ Yes _____ No
If yes, earliest date of service: ___/___/_____

DEA NUMBER (for physicians and psychiatrists only)

If you have a Drug Enforcement Agency (DEA) number, enter it here: _____

LABORATORY INFORMATION

Do you bill laboratory services? _____ Yes _____ No
If yes, enter CLIA Number (**Note:** Up to 10 CLIA types can be added.)

CLIA Number: _______________
CLIA Type: _____ Accreditation _____ Provider-Performed Microscopy Procedures
_____ Compliance (Regular) _____ Registration
_____ Partial Accreditation _____ Waiver
Effective Date: ___/___/_____ Expiration Date: ___/___/_____

CLIA Number: _______________
CLIA Type: _____ Accreditation _____ Provider-Performed Microscopy Procedures
_____ Compliance (Regular) _____ Registration
_____ Partial Accreditation _____ Waiver
Effective Date: ___/___/_____ Expiration Date: ___/___/_____

CLIA Number: _______________
CLIA Type: _____ Accreditation _____ Provider-Performed Microscopy Procedures
_____ Compliance (Regular) _____ Registration
_____ Partial Accreditation _____ Waiver
Effective Date: ___/___/_____ Expiration Date: ___/___/_____

CLIA Number: _______________
CLIA Type: _____ Accreditation _____ Provider-Performed Microscopy Procedures
_____ Compliance (Regular) _____ Registration
_____ Partial Accreditation _____ Waiver
Effective Date: ___/___/_____ Expiration Date: ___/___/_____

CLIA Number: _______________
CLIA Type: _____ Accreditation _____ Provider-Performed Microscopy Procedures
_____ Compliance (Regular) _____ Registration
_____ Partial Accreditation _____ Waiver
Effective Date: ___/___/_____ Expiration Date: ___/___/_____

CLIA Number: _______________
CLIA Type: _____ Accreditation _____ Provider-Performed Microscopy Procedures
_____ Compliance (Regular) _____ Registration
_____ Partial Accreditation _____ Waiver
Effective Date: ___/___/_____ Expiration Date: ___/___/_____

CLIA Number: _______________
CLIA Type: _____ Accreditation _____ Provider-Performed Microscopy Procedures
_____ Compliance (Regular) _____ Registration
_____ Partial Accreditation _____ Waiver
Effective Date: ___/___/_____ Expiration Date: ___/___/_____

CLIA Number: _______________
CLIA Type: _____ Accreditation _____ Provider-Performed Microscopy Procedures
_____ Compliance (Regular) _____ Registration
_____ Partial Accreditation _____ Waiver
Effective Date: ___/___/_____ Expiration Date: ___/___/_____

CLIA Number: _______________
CLIA Type: _____ Accreditation _____ Provider-Performed Microscopy Procedures
_____ Compliance (Regular) _____ Registration
_____ Partial Accreditation _____ Waiver
Effective Date: ___/___/_____ Expiration Date: ___/___/_____

CLIA Number: _______________
CLIA Type: _____ Accreditation _____ Provider-Performed Microscopy Procedures
_____ Compliance (Regular) _____ Registration
_____ Partial Accreditation _____ Waiver
Effective Date: ___/___/_____ Expiration Date: ___/___/_____

FISCAL YEAR-END MONTH

_____ January	_____ May	_____ September
_____ February	_____ June	_____ October
_____ March	_____ July	_____ November
_____ April	_____ August	_____ December

MEDICARE

Are you enrolled in the Medicare program? Yes _____ No _____

PAYMENT AND REMITTANCE ADVICE (RA) INFORMATION

Payments will be made via Electronic Funds Transfer (EFT) unless extenuating circumstances exist. If you feel you have extenuating circumstances that prohibit you from receiving payment via EFT, include a signed letter explaining why paper checks are required to request a waiver.
Please select your payment schedule and RA options. **Note:** Electronic Statement of Remittance (ESOR) is an electronic image of the remittance advice.

_____ Weekly EFT Payment with ESOR
_____ Bi-Weekly EFT with Paper Remittance Advice
_____ Bi-Weekly Paper Check with Paper Remittance Advice (This selection may not be made unless requesting a waiver for a paper check. A signed explanation is required to be submitted with paperwork.)

Do you wish to receive an electronic remittance advice in the HIPAA standard ANSI 835 transaction format?
_____ Yes _____ No
If yes, enter the Submitter ID of the entity you want your 835 delivered to. This is the Submitter ID of your clearinghouse, billing agent, or yourself if you conduct these transactions yourself: _____

NCPDP (NAPB) NUMBER (pharmacy providers only)

Is this a pharmacy that has been recently purchased? _____ Yes _____ No
Do you wish to keep the same NCPDP (NABP) number: _____ Yes _____ No
If yes, what is your NCPDP (NABP) number? _____

PASSPORT

Do you already have a PASSPORT number? _____ Yes _____ No

If yes, enter your current PASSPORT number: _____

CONTACT INFORMATION FOR ENROLLMENT

Provide contact information in case there are questions regarding this enrollment application.

Contact Name: _____
Contact Phone: _____ Extension: _____

Montana Medicaid
Provider Enrollment Agreement and Signature Page

THE PROVIDER CERTIFIES THAT THE INFORMATION PROVIDED ON THIS ENROLLMENT FORM IS, TO THE BEST OF THE PROVIDER'S KNOWLEDGE, TRUE, ACCURATE AND COMPLETE AND THAT THE PROVIDER HAS READ THIS ENTIRE FORM BEFORE SIGNING. IN CONSIDERATION OF MEDICAID PAYMENTS MADE FOR APPROPRIATE MEDICALLY NECESSARY SERVICES RENDERED TO ELIGIBLE CLAIMANTS, AND IN ACCORDANCE WITH ANY RESTRICTIONS NOTED HEREIN, THE PROVIDER AGREES TO THE FOLLOWING:

The Provider hereby agrees to comply with all applicable laws, rules and written policies pertaining to the Montana Medicaid Program (Medicaid), including but not limited to Title XIX of the Social Security Act, the Code of Federal Regulations (CFR), Montana Codes Annotated (MCA), Administrative Rules of Montana (ARM) and written Department of Public Health and Human Services (Department) policies, including but not limited to policies contained in the Medicaid provider manuals, and the terms of this document.

The Provider certifies that the care, services and supplies for which the Provider bills Medicaid will have been previously furnished, the amounts listed will be due, and except as noted, no part thereof will have been paid. Payment for services made in accordance with established rates, schedules or methodologies will be accepted as payment in full.

The Provider assures the Department that the Provider is an independent contractor providing services for the Department and that neither the Provider nor any of the Provider's employees are employees of the Department under this enrollment form or any subsequent amendment. The Provider is solely responsible for and shall meet all legal requirements, including payment of all applicable taxes, workers compensation, unemployment and other premiums, deductions, withholdings, overtime and other amounts which may be legally required with respect to the Provider and the employment of all persons providing services under this enrollment form.

The Provider agrees to comply with the requirements concerning advance directives at 42 U.S.C. 1396a(w).

The Provider agrees to comply with those federal requirements and assurances for recipients of federal grants provided in OMB Standard Form 424B (7/97) which are applicable to the Provider. The Provider is responsible for determining which requirements and assurances are applicable to the Provider. Copies of the form are available from the Department. The Provider shall provide for the compliance of any subcontractors with applicable federal requirements and assurances. The Provider, as provided by 31 U.S.C. 1352 and 45 CFR 93.100 et seq., shall not pay federally appropriated funds to any person for influencing or attempting to influence an officer of employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress in connection with the awarding of any federal contract, the making of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement.

The Provider agrees to comply with the applicable provisions of the Civil Rights Act of 1964 (42 U.S.C. 200d, et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990 (42 U.S.C. 12101, et seq.) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794).

The Provider may not, on the grounds of race, color, national origin, creed, sex, religion, political ideas, martial status, age or disability exclude persons from employment in, deny participation in, deny benefits to, or otherwise subject persons to discrimination under the Medicaid program or and any active connected with the provision of Medicaid services. All hiring done in connection with the provision of Medicaid services must be on the basis of merit qualifications genuinely related to competent performance of the particular occupational task. The Provider, in accordance with federal Executive Orders 11246 and 11375 and 41 CFR Part 60, must provide for equal employment opportunities in its employment practices. The Provider shall use hiring processes that foster the employment and advancement of qualified persons with disabilities.

The Provider agrees, in accordance with federal and state laws, regulations and policies including 45 CFR Subpart F or Part 431 pertaining to Medicaid recipients, to protect the confidentiality of any material and information concerning an applicant for or recipient of services funded with Medicaid monies. For purposes of the delivery of services under this Agreement, the Provider is a health care provider that must comply, as applicable, with the privacy and security

requirements of the Health Insurance Portability And Accountability Act (HIPAA) of 1996 as adopted at 45 CFR Part 160 and Subparts A, C, and E of Part 164.

The Provider agrees to make and maintain records, as required by applicable laws, regulations, rules and policies, which fully demonstrate the extent, nature and medical necessity of services and items provided to recipients, which support the fee charged or payment sought for the services and items, and which demonstrate compliance with all applicable requirements. The Provider agrees to furnish on request to the Department, the United States Department of Health and Human Services, the Montana Medicaid Fraud Control Unit and any other authorized governmental agency or agent thereof any records maintained under applicable laws, regulations, rules and policies.

The Provider agrees to comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B, including but not limited to disclosure of information regarding ownership and control, business transactions and persons convicted of crimes. Upon request, the provider agrees to provide to the Department and the U.S. Department of Health and Human Services the information required in 42 U.S.C.A. §1396b(s) pertaining to limitations on certain physician referrals.

The Provider agrees to repay to the Department (1) the amount of any payment under the Medicaid program to which the Provider was not entitled, regardless of whether the incorrect payment was the result of Department or provider error other cause, and (2) the portion of any interim rate payment that exceeds the rate determined retrospectively the Department for the rate period.

The Provider agrees to notify ACS at the address stated below within 30 days of a change in any of the information in this enrollment form.

The Provider acknowledges that this enrollment is effective only for the category of services stated above and that a separate provider enrollment form must be submitted for each additional category of services (i.e., Hospital, Swing Bed, Waiver, Home Health, etc.) for which Medicaid reimbursement is sought.

The Provider, if meeting the applicable criteria, agrees to comply with 42 U.S.C. 1396a(a)(68) of the Social Security Act requiring employee education about the federal False Claims Act. This provision applies to those providers furnishing items or services at more than a single location or under more than one contractual or other payment arrangement and receiving aggregate payments of Medicaid monies totaling $5,000,000 or more annually. It is the responsibility of the provider to establish written policies for all employees that include detailed information about the False Claims Act and the other provisions named in 42 U.S.C. 1396a(a)(68)(A).

I UNDERSTAND THAT PAYMENT OF CLAIMS WILL BE FROM FEDERAL AND STATE FUNDS AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAW.

Printed Name of Individual Practitioner: _____
Signature of Individual Practitioner:_____ Date:_____

Or for facilities and non-practitioner organizations:

Printed Name of Authorized Representative: _____ Title/Position:_____
Address: _____Telephone Number:_____
Signature of Authorized Representative: _____ Date:_____

ACS
Montana Provider Relations
P.O. Box 4936
Helena, MT 59604

Montana Medicaid
License, CLIA and Certification

Attach your license, CLIA and applicable certification below.

ACS EDI Gateway
Trading Partner Agreement

THIS TRADING PARTNER AGREEMENT ("Agreement") is by and between **SUBMITTER** ("Submitter") and **ACS EDI GATEWAY, INC.** ("Trading Partner"), collectively "the Parties."

Whereas, Submitter desires to transmit Transactions to Trading Partner for the purpose of submitting data to a Health Plan;

Whereas, Trading Partner desires to receive such Transactions for this purpose recognizing that Trading Partner performs such services on behalf of the Health Plan; and

Whereas, Submitter is subject to the Transaction and Code Set Regulations with respect to the transmission of such Transactions.

Now, therefore, the Parties agree as follows:

1. Definitions
Trading Partner means ACS EDI Gateway, Inc. Submitter means the party identified as "Submitter" on the signature line of this Agreement who is a Health Care Provider as defined in 45 CFR 164.103. Standard is defined in 45 CFR 160.103. Transaction is defined in 45 CFR 160.103. Transactions and Code Set Regulations means those regulations governing the transmission of certain health claims transactions as published by DHHS under HIPAA.

2. Obligations of the Parties Effective Upon Execution of this Agreement by Submitter

A. The Parties agree, in regard to any electronic Transactions between them:
   (1) They will exchange data electronically using only those Transaction types as selected by Submitter on the ACS EDI Gateway Trading Partner Enrollment Form (TPEF).
   (2) They will exchange data electronically using only those formats (versions) as specified on the TPEF.
   (3) They will not change any definition, data condition, or use of a data element or segment in a Standard Transaction they exchange electronically.
   (4) They will not add any data elements or segments to the Maximum Defined Data Set.
   (5) They will not use any code or data elements that are not in or are marked as "Not Used" in a Standard's implementation specification.
   (6) They will not change the meaning or intent of a Standard's implementation specification.
   (7) Trading Partner may reject a Transaction submitted by Submitter if the Transaction is not submitted using the data elements, formats, or Transaction types set forth in the TPEF. Trading Partner may refuse to accept any claims from Submitter if Submitter repeatedly submits Transactions which do not meet the criteria set forth in a TPEF or if Submitter repeatedly submits inaccurate or incomplete Transactions to Trading Partner.

B. Submitter understands that Trading Partner or others may request an exception from the Transaction and Code Set Regulations from DHHS. If an exception is granted, Submitter will participate fully with Trading Partner in the testing, verification, and implementation of a modification to a Transaction affected by the change.

C. Trading Partner understands that DHHS may modify the Transaction and Code Set Regulations. Trading Partner will modify, test, verify, and implement all modifications or changes required by DHHS using a schedule mutually agreed upon by Submitter and Trading Partner.

D. Neither Submitter nor Trading Partner accepts responsibility for technical or operational difficulties that arise out of third party service providers' business obligations and requirements that undermine Transaction exchange between Submitter and Trading Partner.

E. Submitter and Trading Partner will exercise diligence in protection of the identity, content, and improper access of business documents exchanged between the two parties. Submitter and Trading Partner will make reasonable efforts to protect the safety and security of individually assigned identification numbers that are contained in transmitted business documents and used to authenticate relationships between the parties.

F. Trading Partner may publish data clarifications ("ACS Companion Guides") to complement each Implementation Guide. Submitter should use ACS Companion Guides in conjunction with the HIPAA Implementation Guides available at http://www.wpc-edi.com/hipaa.

G. Transactions are considered properly received only after accessibility is established at the designated machine of the receiving party. Once transmissions are properly received, the receiving party will promptly transmit an electronic acknowledgment that conclusively constitutes evidence of properly received transactions. Each party will

subject information to a virus check before transmission to the other party.

H. Each party will implement and maintain appropriate policies and procedures and mechanisms to protect the confidentiality and security of PHI transmitted between the parties.

3. Miscellaneous

A. This Agreement is effective on the date last signed below. This Agreement shall continue until such time as either party elects to give written notice of termination to the other party or termination of Transaction services provided by Trading Partner to Submitter, whichever is earlier.

B. This Agreement incorporates, by reference, any written agreements between the parties relating to the subject matter hereof.

C. This Agreement shall be interpreted consistently with all applicable federal and state privacy laws. In the event of a conflict between applicable laws, the more stringent law shall be applied. This Agreement and all disputes arising from or relating in any way to the subject matter of this Agreement shall be governed by and construed in accordance with Montana law, exclusive of conflicts of law principles. THE EXCLUSIVE JURISDICTION FOR ANY LEGAL PROCEEDING REGARDING THIS AGREEMENT SHALL BE IN THE COURTS OF THE STATE OF MONTANA AND THE PARTIES HEREBY EXPRESSLY SUBMIT TO SUCH JURISDICTION.

D. Unless otherwise prohibited by statute, the parties agree that this Agreement shall not be affected by any state's enactment or adoption of the Uniform Computer Information Transaction Act, Electronic Signature or any other similar state or federal law. Each party agrees to comply with all other applicable state and federal laws in carrying out its responsibilities under this Agreement.

E. This Agreement is entered into solely between, and may be enforced only by, Submitter and Trading Partner. This Agreement shall not be deemed to create any rights in third parties or to create any obligations of Submitter or Trading Partner to any third party.

F. NO WARRANTIES, EXPRESS OR IMPLIED, ARE PROVIDED BY TRADING PARTNER UNDER THIS AGREEMENT. TRADING PARTNER'S MAXIMUM AGGREGATE LIABILITY FOR DAMAGES FOR ANY AND ALL CAUSES WHATSOEVER ARISING OUT OF THIS AGREEMENT, REGARDLESS OF THE MANNER IN WHICH CLAIMED OR THE FORM OF ACTION ALLEGED, IS LIMITED TO THE AMOUNT(S) PAID TO TRADING PARTNER BY SUBMITTER UNDER THIS AGREEMENT.

G. Trading Partner may provide proprietary software to Submitter to allow Submitter to submit Transactions to Trading Partner. Submitter will protect the software as it protects its own confidential information and will not, directly or indirectly, allow access to or the use of the software or any portion thereof, on any computer, server, or network, by any person, corporation, or business entity other than Submitter. Submitter may permit use of the software by contractors or agents of Submitter provided that any such contractors or agents are not competitors of Trading Partner and further provided that any such persons agree to protect the confidentiality of the software. Submitter and its contractors and agents are not permitted to use the software for any purpose other than submitting Transactions solely to Trading Partner.

H. This Agreement contains the entire agreement between the parties and may only be modified by an agreement signed by both parties.

I. Submitter may elect to execute either a hard copy or an electronic copy of this Agreement. Hard Copy Execution: Submitter will sign a hard copy of this Agreement and mail to Trading Partner at the address indicated below. Trading Partner will return a copy of the fully executed Agreement to Submitter. The effective date of the hard copy Agreement is the date on which the Agreement is signed by Trading Partner. Electronic Copy Execution: Submitter should execute this Agreement by clicking on the "I AGREE" button that appears at the bottom of the Agreement. The effective date of the electronic copy agreement is the date Trading Partner receives the electronic transmission of Submitter's acceptance to the terms of this Agreement.

SUBMITTER:

Provider/Trading Partner ID: _____

(For Pharmacies Only)

NCPDP ID: _____

Other Pharmacy ID Type: _____

Other ID Number: _____

Signature: _____

Printed Name and Title: _____

Date: _____

Form **W-9**
(Rev. January 2003)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► _____ ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 3.

Note: *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

Social security number
___ ___ ___ – ___ ___ – ___ ___ ___ ___

or

Employer identification number
___ ___ – ___ ___ ___ ___ ___ ___ ___

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item **2** above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item **2** does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here **Signature of U.S. person** ► **Date** ►

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a **nonresident alien or a foreign entity** not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments (29% **after** December 31, 2003; 28% **after** December 31, 2005). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will **not** be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under **4** above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate **Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note: *You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).*

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note: *If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.*

Exempt payees. Backup withholding is **not required** on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2);

2. The United States or any of its agencies or instrumentalities;

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities;

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities; or

5. An international organization or any of its agencies or instrumentalities.

Other payees that **may be exempt** from backup withholding include:

6. A corporation;

7. A foreign central bank of issue;

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States;

9. A futures commission merchant registered with the Commodity Futures Trading Commission;

10. A real estate investment trust;

11. An entity registered at all times during the tax year under the Investment Company Act of 1940;

12. A common trust fund operated by a bank under section 584(a);

13. A financial institution;

14. A middleman known in the investment community as a nominee or custodian; or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, **1** through **15.**

If the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for **9**
Broker transactions	Exempt recipients **1** through **13.** Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients **1** through **5**
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients **1** through **7** [2]

[1] See **Form 1099-MISC**, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are **not exempt** from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner **LLC** that is disregarded as an entity separate from its owner (see **Limited liability company (LLC)** on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note: *See the chart on page 4 for further clarification of name and TIN combinations.*

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5,** Application for a Social Security Card, from your local Social Security Administration office or get this form on-line at **www.ssa.gov/online/ss5.html**. You may also get this form by calling 1-800-772-1213. Use **Form W-7,** Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or **Form SS-4,** Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS Web Site at **www.irs.gov**.

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: *Writing "Applied For" means that you have already applied for a TIN* ***or*** *that you intend to apply for one soon.*

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see **Exempt from backup withholding** on page 2.

Signature requirements. Complete the certification as indicated in **1** through **5** below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item **2** in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item **2** of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA or Archer MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] **You must show your individual name,** but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: *If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.*

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or Archer MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, or to Federal and state agencies to enforce Federal nontax criminal laws and to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 30% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

Standard Form 1199A
(Rev. June 1987)
Prescribed by Treasury Department
Treasury Dept. Cir. 1076

OMB No. 1510-0007

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for direct deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER

Prefix Suffix

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*

- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed Salary/Mil. Civilian Pay
- ☐ Mil. Active _____
- ☐ Mil. Retire. _____
- ☐ Mil. Survivor _____
- ☐ Other _____ *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE	DATE
SIGNATURE	DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE
SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER CHECK DIGIT

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENRATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE

Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

NSN 7540-01-058-0224

1199-207

BURDEN ESTIMATE STATEMENT

The estimated average burden associated with this collection of information is 10 minutes per respondent or recordkeeper, depending on individual circumstances. Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be directed to the Financial Management Service, Facilities Management Division, Property & Supply Section, Room B-101, 3700 East-West Highway, Hyattsville, MD 20782 or the Office of Management and Budget, Paperwork Reduction Project (1510-0007), Washington, D.C. 20503.

PLEASE READ THIS CAREFULLY

All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

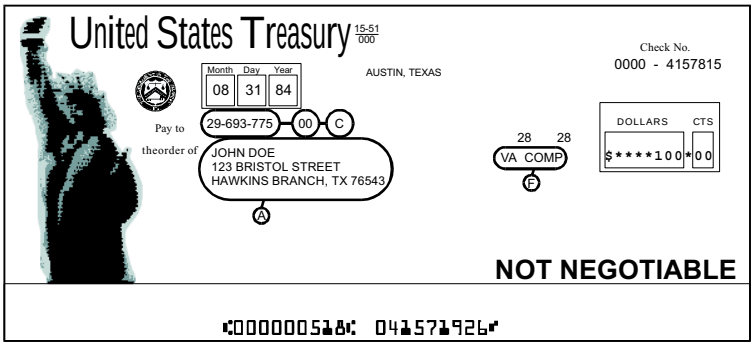
INFORMATION FOUND ON CHECKS

Most of the information needed to complete boxes A, C, and F in Section 1 is printed on your government check:

Ⓐ Be sure that the payee's name is written exactly as it appears on the check. Be sure current address is shown.

Ⓒ Claim numbers and suffixes are printed here on checks beneath the date for the type of payment shown here. Check the Green Book for the location of prefixes and suffixes for other types of payments.

Ⓕ Type of payment is printed to the left of the amount.



SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

CANCELLATION

The agreement represented by this authorization remains in effect until canceled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

CHANGING RECEIVING FINANCIAL INSTITUTIONS

The payee's Direct Deposit will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the Direct Deposit. To effect this change, the payee will complete the new SF 1199A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is complete, i.e. after the new financial institution receives the payee's Direct Deposit payment.

FALSE STATEMENTS OR FRAUDULENT CLAIMS

Federal law provides a fine of not more than $10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.

CHIP Dental Provider Agreement and Signature

The provider certifies that the information provided on this enrollment form is to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. In consideration of CHIP payments made for appropriate medically necessary services rendered to eligible claimants, and in accordance with any restrictions noted herein, the provider agrees to the following:

The provider hereby agrees to comply with all applicable laws, rules and written policies pertaining to the Montana CHIP program, including but not limited to Title XXI of the Social Security Act, the Code of Federal Regulations (CFR), Montana Codes Annotated (MCA), Administrative Rules of Montana (ARM) and written Department of Public Health and Human Services (Department) policies, and the terms of this document.

The provider certifies that the care, services and supplies for which the provider bills CHIP will have been previously furnished, the amounts listed will be due, and except as noted, no part thereof will have been paid. Payment for services made in accordance with established rates, schedules or methodologies will be accepted as payment in full.

The provider assures the Department that the provider is an independent contractor providing services for the Department and that neither the provider nor any of the provider's employees are employees of the Department under this enrollment form or any subsequent amendment. The provider is solely responsible for and shall meet all legal requirements, including payment of all applicable taxes, workers compensation, unemployment and other premiums, deductions, withholdings, overtime and other amounts which may be legally required with respect to the provider and the employment of all persons providing services under this enrollment form.

The provider agrees to comply with those federal requirements and assurance for recipients of federal grants provided in OMB Standard Form 424B (7/97) which are applicable to the provider. The provider is responsible for determining which requirements and assurances are applicable to the provider. Copies of the form are available from the Department. The provider shall provide for the compliance of any subcontractors with applicable federal requirements and assurances. The provider, as provided by 31 U.S.C. 1352 and 45 CFR 93.100 et seq., shall not pay federally appropriated funds to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress in connection with the awarding of any federal contract, the making of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement.

The provider agrees to comply with the applicable provisions of the Civil Rights Act of 1964 (42 U.S.C. 200d, et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990 (42 U.S.C. 12101, et seq.) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C.794).

The provider may not, on the grounds of race, color, national origin, creed, sex, religion, political ideas, marital status, age or disability exclude persons from employment in, deny participation in, deny benefits to, or otherwise subject persons to discrimination under the CHIP program or any activity connected with the provision of CHIP services.

All hiring done in connection with the provision of CHIP services must be on the basis of merit qualifications genuinely related to competent performance of the particular occupational task. The provider, in accordance with federal Executive Orders 11246 and 11375 and 41 CFR Part 60, must provide for equal employment opportunities in its employment practices. The provider shall use hiring processes that foster the employment and advancement of qualified persons with disabilities.

The Provider agrees, in accordance with federal and state laws, regulations and policies including 45 CFR Subpart F or Part 431 pertaining to Medicaid recipients, to protect the confidentiality of any material and information concerning an applicant for or recipient of services funded with Medicaid monies. For purposes of the delivery of services under this Agreement, the Provider is a health care provider that must comply, as applicable, with the

privacy and security requirements of the Health Insurance Portability And Accountability Act (HIPAA) of 1996 as adopted at 45 CFR Part 160 and Subparts A, C, and E of Part 164.

The provider agrees to make and maintain records, as required by applicable laws, regulations, rules and policies, which fully demonstrate the extent, nature and medical necessity of services and items provided to recipients, which support the fee charged or payment sought for the services and items, and which demonstrate compliance with all applicable requirements. The provider agrees to furnish on request to the Department, the United State Department of Health and Human Services, and any other authorized governmental agency or agent thereof any records maintained under applicable laws, regulations, rules and policies.

The provider agrees to comply with the disclosure requirements specified in 42 CFR, part 455, subpart B, including but not limited to disclosure of information regarding ownership and control, business transactions and persons convicted of crimes. Upon request, the provider agrees to provide to the Department and the U.S. Department of Health and Human Services the information required in 42 U.S.C.A. §1396b(s) pertaining to limitations on certain physician referrals.

The provider agrees to repay to the Department (1) the amount of any payment under the CHIP program to which the provider was not entitled, regardless of whether the incorrect payment was the result of Department or provider error or other cause, and (2) the portion of any interim rate payment that exceeds the rate determined retrospectively by the Department for the rate period.

The provider agrees to notify ACS at the address stated below within 30 days of a change in any of the information in this enrollment form.

The provider acknowledges that this enrollment is effective only for the category of services stated above and that a separate provider enrollment form must be submitted for each additional category of services (i.e., dental, eyeglasses, etc.) for which CHIP reimbursement is sought. Dental services that are covered as a medical service by the CHIP Third Party Administrative (TPA) Contract must be in accordance with the CHIP benefit plan. Claims for these dental services must be submitted to the TPA contractor and not directly to the Department.

I understand that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Individual Practitioner: _____
Signature of Individual Practitioner:_____ Date:_____

Or for facilities and non-practitioner organizations:

Printed Name of Authorized Representative: _____ Title/Position:_____
Address: _____ Telephone Number:_____
Signature of Authorized Representative: _____ Date:_____

ACS
Montana Provider Relations
P.O. Box 4936
Helena, MT 59604

CHIP Provider Agreement and Signature for Extended Mental Health Benefits for Children with a Serious Emotional Disturbance (SED)

The Provider certifies the information provided on this enrollment form is to the best of the Provider's knowledge true, accurate, and complete and the Provider has read this entire form before signing. In consideration of CHIP payments made for appropriate medically necessary services rendered to eligible claimants, and in accordance with any restrictions noted herein, the Provider agrees to the following:

The Provider states it is an enrolled Medicaid Provider and it may only continue as a Provider of benefits under the Children's Health Insurance Plan (CHIP) Extended Mental Health Benefits Plan for Children with SED if it remains a Medicaid Provider in good standing. The Provider acknowledges the terms and conditions of its Medicaid Provider enrollment agreement also apply to this agreement.

The Provider agrees to comply with all applicable laws, rules and written policies pertaining to the Montana CHIP program, including but not limited to: Title XXI of the Social Security Act, the Code of Federal Regulations (CFR), Montana Codes Annotated (MCA), Administrative Rules of Montana (ARM) and written Department of Public Health and Human Services (Department) policies, and procedure manuals and the terms of this document.

The Provider certifies that the care, services and supplies for which the Provider bills CHIP will have been previously furnished, the amounts listed will be due, and except as noted, no part thereof will have been paid. Payment for services made in accordance with established rates, schedules or methodologies will be accepted as payment in full. **THE PROVIDER'S AGREEMENT AND SIGNATURE ON THIS FORM SERVES AS NOTIFICATION TO THE PROVIDER THAT PAYMENT FOR SERVICES THROUGH THE CHIP EXTENDED MENTAL HEALTH BENEFITS FOR CHILDREN WITH SED WILL BE AT THE RATES PROVIDED IN THE MEDICAID MENTAL HEALTH AND MENTAL HEALTH SERVICE PLAN FEE SCHEDULE.**

The Provider assures the Department the Provider is an independent contractor providing services to CHIP enrollees and neither the Provider nor any of the Provider's employees are employees of the Department under this enrollment form or any subsequent amendment. The Provider is solely responsible for and shall meet all legal requirements, including payment of all applicable taxes, workers compensation, unemployment and other premiums, deductions, withholdings, overtime and other amounts which may be legally required with respect to the Provider and the employment of all persons providing services under this enrollment form.

The Provider agrees to comply with those federal requirements and assurance for recipients of federal grants provided in OMB Standard Form 424B(7/97) which are applicable to the Provider. The Provider is responsible for determining which requirements and assurances are applicable to the Provider. Copies of the form are available from the Department. The Provider shall provide for the compliance of any subcontractors with applicable federal requirements and assurances. The Provider, as provided by 31 U.S.C. 1352 and 45 CFR 93.100 et. seq., shall not pay federally appropriated funds to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress, in connection with the awarding of any federal contract, the making of any cooperative agreement, or the extension, continuations, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement.

The Provider agrees to comply with the applicable provisions of the Civil Rights Act of 1964 (42 U.S.C.200d, et seq.), the Age Discrimination Act of 1975 (42 U.S.C.6101, et seq.), the Americans with Disabilities Act of 1990 (42 U.S,C. 12101, et seq.) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794).

The Provider may not, on the grounds of race, color, national origin, creed, sex, religion, political ideas, marital status, age or disability exclude persons from employment in, deny participation in, deny benefits to, or otherwise subject persons to discrimination under the CHIP program or any activity connected with the provision of CHIP services. All hiring done in connection with the provision of CHIP services must be on the basis of merit qualifications genuinely

related to competent performance of the particular occupational task.. The Provider, in accordance with federal Executive Orders 11246 and 11375 and 41 CFR Part 60, must provide for equal employment opportunities in its employment practices. The Provider shall use hiring processes that foster the employment and advancement of qualified persons with disabilities.

The Provider further agrees to, in accordance with relevant laws, regulations and policies, including the 1996 Department Policy on Confidentiality of Client Information and the Health Insurance Portability and Accountability Act (HIPAA), protect the confidentiality of any material and information concerning an applicant for or recipient of CHIP services.

The Provider agrees to make and maintain records, as required by applicable laws, regulations, rules and policies, which fully demonstrate the extent, nature and medical necessity of services and items provided to recipients, which support the fee charged or payment sought for the services and items, and which demonstrate compliance with all applicable requirements. The Provider agrees to furnish on request to the Department, the United States Department of Health and Human Services, and any other authorized governmental agency or agent thereof any records maintained under applicable laws, regulations, rules and policies.

The Provider agrees to comply with the disclosure requirements specified in 42 CFR, part 455, subpart B, including but not limited to disclosure of information regarding ownership and control, business transactions and persons convicted of crimes. Upon request, the Provider agrees to provide to the Department and the U.S. Department of Health and Human Services the information required in 42 U.S.C.A. §1396b(s) pertaining to limitations on certain physician referrals.

The Provider agrees to repay to the Department (1) the amount of any payment under the CHIP program to which the Provider was not entitled, regardless of whether the incorrect payment was the result of Department or Provider error or other cause, and (2) the portion of any interim rate payment that exceeds the rate determined retrospectively by the Department for the rate period.

The Provider agrees to notify ACS at: ACS Provider Enrollment Unit, PO Box 4936, Helena, MT 59604 within 30 days of a change in any of the information in this enrollment form.

The Provider acknowledges that this enrollment is effective only for the following services to the extent a CHIP enrollee qualifies for the service: Therapeutic Group Home; Therapeutic Family Care (moderate level); Day Treatment; Community Based Psychiatric Rehabilitation and Support (therapeutic aide); Individual therapy; Family therapy; and Respite Care. A separate Provider enrollment form must be submitted for any additional category of services for which CHIP reimbursement is sought.

I understand claims payment will be from federal and state funds and any falsification or concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Individual Practitioner: _____
Signature of Individual Practitioner:_____ Date:_____

Or for facilities and non-practitioner organizations:

Printed Name of Authorized Representative: _____ Title/Position:_____
Address: _____Telephone Number:_____
Signature of Authorized Representative: _____ Date:_____

ACS
Montana Provider Relations
P.O. Box 4936
Helena, MT 59604

Mental Health Services Plan
Provider Enrollment Addendum

Montana Medicaid Provider Number: _____

The individual or entity identified below has applied for enrollment and is enrolled as a provider in the Montana Medicaid Program ("Medicaid"), and has also requested enrollment as a provider under the Mental Health Services Plan established in ARM Title 46, Chapter 20 (the "Plan").

In consideration of enrollment in the Plan and Plan payments made to the Provider for covered medically necessary services under the Plan, the Provider acknowledges and agrees to the following:

As a condition of participation in the Plan, the Provider must be and remain enrolled as a Medicaid Provider. Participation in the Plan shall be limited to the category or categories of services which is a covered service under the Plan and for which the Provider is enrolled in Medicaid.

The Provider agrees to comply with and be bound by all applicable laws, regulations, rules and written policies pertaining to the Plan, and those Medicaid laws, regulations, rules and written policies applicable under the Plan, including but not limited to the Montana Code Annotated, the Administrative Rules of Montana and written policies of the Department of Public Health and Human Services (DPHHS).

DPHHS is authorized to use the information contained in the Provider's Medicaid Provider Agreement for purposes of administering the Plan. Provider acknowledges and agrees that the provisions of the Medicaid Provider Agreement shall apply to the Plan as if the Plan services were Medicaid services, except that this Addendum shall not be construed to make applicable to the Plan any provisions of State or Federal laws, regulations, rules and policies not otherwise applicable to the Plan.

Enrollment in the Plan under this Addendum shall be effective according to the same provisions applicable to Medicaid enrollment under ARM 46.12.302. This addendum shall terminate, without affecting the Provider's Medicaid Provider Agreement, upon written notice by DPHHS to the Provider or upon the termination of the Plan.

This Addendum shall be a part of the Provider's Medicaid Provider Agreement for purposes of governing the Provider's participation in the Plan. However, this Addendum shall not in any way reduce or modify the Provider's obligations under the Provider's Medicaid Provider Agreement with respect to participation or provision of services under the Montana Medicaid Program.

Printed Name of Individual Practitioner: _____
Signature of Individual Practitioner:_____ Date:_____

Or for facilities and non-practitioner organizations:

Printed Name of Authorized Representative: _____ Title/Position:_____
Address: _____ Telephone Number:_____
Signature of Authorized Representative: _____ Date:_____

Comprehensive School and Community Treatment Services Contract

This contract contains boilerplate language that may be utilized and modified by the parties involved to specify the requirements appropriate for the School and CSCT provider. As with any legal document, your legal staff should review the contract prior to parties signing to ensure language meets the requirements of the involved parties.

SECTION 1. PARTIES. The Parties to this Comprehensive School and Community Treatment Contract (hereinafter "Contract") are:

The Board of Trustees of School District No. ____, _____ County, a political subdivision of the State of Montana providing public education (hereinafter "School District"), and

_____, a (Corporation/Partnership/Sole Proprietor) (hereinafter "Vendor") that holds all federal and state licenses required to provide Comprehensive School and Community Treatment Services (hereinafter "CSCT"). Vendor specifically represents that it is an entity that can satisfy all federal and state medical licensure requirements to enable School District to recoup Medicaid funds for costs incurred for the provision of CSCT.

SECTION 2. PURPOSE. The Parties enter into this Contract for the following purpose:

Vendor will provide CSCT Services, according to the terms of this contract, to all School District students authorized by the School District to receive CSCT. As used in this agreement the term CSCT means Comprehensive School and Community Treatment.

SECTION 3. TERM OF CONTRACT. This Contract shall be effective as of _____, 20__ , and shall continue in effect through _____unless terminated earlier as provided in Section 9 below.

SECTION 4. SERVICES TO BE PROVIDED BY VENDOR.

4.1. Vendor agrees to render CSCT services to School District in accordance with the Statement of Work attached hereto as Exhibit 1 and incorporated by reference. For all students, Vendor shall submit monthly progress reports, including service documentation, supporting the provision of CSCT services.

4.2. Vendor will maintain and submit to School District sufficient documentation of services to enable School District to bill for Medicaid covered services provided to Medicaid eligible children. Vendor will bill third party insurers for all CSCT Medical services provided to non-Medicaid eligible children in the amount, scope and duration required by the Montana Department of Public Health and Human Services to satisfy third party liability requirements. For those children ineligible for Medicaid and uninsured, Vendor will bill the parents for services rendered utilizing their fee schedule.

SECTION 5. CREATION AND RETENTION OF RECORDS.

5.1. The Vendor must create and maintain records of the services covered by this contract, including financial records, supporting documents, and such other records as are required by law or other authority.

5.2. Vendor shall maintain books, records, and documents in accordance with federal and state medical documentation requirements, accounting procedures and practices which sufficiently and properly reflect the services rendered and funds expended in connection with this Contract. All service/program notes, books, medical records, documents, or other materials associated with this Contract shall be subject to reasonable inspection, review, or audit by School District and/or the Montana Department of Public Health and Human Services and/or Centers for Medicare and Medicaid Services and their designees, during Vendor's usual business hours and upon prior notice. Vendor shall retain all medical service progress notes, student

case files/ medical records, financial and other records pertaining to its work under this Contract for six (6) years three (3) months from the date of the completion, termination or expiration of this Contract or the conclusion of any audit pertaining to this Contract, whichever is later. If any litigation, review, claim or audit is started before the expiration of this period, the records must be retained until all litigation, reviews, claims or audit findings involving the records have been resolved.

SECTION 6. CHANGES TO VENDOR'S WORK WITHIN STATEMENT OF WORK.

6.1 School District may, at any time by written notice, make changes in the Vendor's work within the general scope of the Statement of Work. If any change under this section causes an increase or decrease in the Vendor's cost of, or time required for, the performance of any part of the work, the parties shall negotiate an equitable adjustment to the compensation payable hereunder, and this Contract shall be modified in writing accordingly. If the Parties cannot reach a mutually agreeable adjustment after good faith negotiations either Party may terminate this contract.

6.2. The parties agree to negotiate in good faith to revise this Contract in the event of:

6.2.1 Legislation or court action that affects this Contract or State Medicaid Coverage;

6.2.2 Changes in the funds available that affect this Contract; or

6.2.3 Other changes reasonably requested by School District necessary to make this Contract consistent with federal and state Medicaid billing requirements.

If the Parties cannot reach a mutually agreeable adjustment after good faith negotiations either Party may terminate this contract.

SECTION 7. SCHOOL DISTRICT'S OBLIGATIONS.

7.1. School District agrees to provide the Vendor with office space, phone, computer, printer, Internet and E-mail access, and reasonable office supplies.

7.2 School District agrees to provide the Vendor with the following additional services:_____
_____
_____
_____ (If none so note.)

SECTION 8. CONSIDERATION AND PAYMENTS.

8.1. Amount of compensation. School District shall pay Vendor in accordance the Payment Schedule attached hereto as Exhibit 2. Vendor agrees that such rates shall not increase during the term of this Contract.

8.2 Manner of Payment. Vendor shall prepare and submit to School District an invoice, by the tenth (10th) day of each month, showing CSCT student load, student Medicaid eligibility status and corresponding Medicaid number if applicable, services performed for each student, and the number of days for which services were provided to the student. School District shall pay the Vendor within thirty (30) days after receipt and approval of the invoice and any required supporting documentation.

SECTION 9. TERMINATION.

9.1 This Contract may be terminated with written notice prior to the expiration of the term of the Contract for the following reasons:

9.1.1 The District may immediately terminate the whole or any part of this contract for failure to perform the contract in accordance with the terms of the contract and other governing authorities.

9.1.2 Either Party shall have the right to terminate this Contract if the other Party is in default of any obligation hereunder and such default is not cured within thirty (30) days of receipt of a notice from the non-defaulting Party specifying such default.

9.1.3 This Contract may be terminated by School District upon written notice to the Vendor if:

9.1.3.1 The Montana Department of Public Health and Human Services (DPHHS) for any reason terminates Medicaid coverage of the CSCT program in the State of Montana

9.1.3.2 The DPHHS no longer allows the School District to recoup Medicaid reimbursement for the provision of CSCT services to Medicaid eligible children; and,

9.1.3.3 Vendor does not meet federal and state CSCT licensure and service requirements.

9.2 If this contract is terminated early School District shall compensate Vendor for services performed up to the date of written notice of termination less any amounts that are the subject of a good faith dispute. In no event, however, shall the amount payable to Vendor in connection with a termination exceed the total value of this Contract as set forth on Exhibit 2.

SECTION 10. CESSATION OF SERVICES, RETURN OF PROPERTY, COMPENSATION.

10.1 Upon the expiration of the term of this Contract, or earlier termination as provided in Section 9, Vendor shall: cease to provide CSCT services hereunder, submit any outstanding monthly progress reports, including service documentation and invoices described in Sections 4 and 5, and deliver to School District all property relating to the business and work of School District. Such property shall include but not be limited to all office space, phone, computer, printer, Internet and E-mail access, and reasonable office supplies.

10.2 Upon the expiration of the term of this Contract, or earlier termination as provided in Section 6, School District shall: compensate Vendor for services performed up to the date of written notice of termination less any amounts that are the subject of a good faith dispute. In no event, however, shall the amount payable to Vendor in connection with a termination exceed the total value of this Contract as set forth on Exhibit 2. School District's obligation to pay is contingent on the receipt from Vendor of monthly progress reports, including service documentation and invoices, and all School District property.

SECTION 11. STANDARD OF PERFORMANCE. Vendor warrants and represents that it possesses the special skill and professional competence, licensure, expertise and experience to undertake the obligations imposed by this Contract. Vendor agrees to perform in a diligent, efficient, competent and skillful manner commensurate with the highest standards of the profession, and to devote such time as is necessary to perform the services required under this Contract. Vendor agrees to remove and replace any of its personnel who, in the sole judgment of School District, are not performing there responsibilities at an acceptable level.

SECTION 12. INDEMNIFICATION. Vendor agrees to defend, indemnify and hold School District harmless from and against any and all claims, losses, liabilities or expenses (including, without limitation, attorneys' fees) which may arise, in whole or in part, out of (i) the negligence or willful misconduct of the Vendor, its employees or agents, and/or (ii) a breach by the Vendor of its obligations under this Contract. The indemnity required herein shall not be limited by reason of the specification of any particular insurance coverage.

SECTION 13. INSURANCE.

13.1 General Liability. The Vendor must maintain, at its cost, primary standard general liability insurance coverage. The general liability coverage must include claims arising out of contractual liability, the delivery of services, omissions in the delivery of services, injuries to persons, damages to property, the provision of goods or rights to intellectual property or any other liabilities that may arise in the provision of services under this contract. The insurance must cover claims as may be caused by any act, omission, or negli-

gence of the Vendor and/or its officers, agents, employees, representatives, assigns or subcontractors.

13.1.1 The Vendor must provide general liability insurance coverage inclusive of bodily injury, personal injury and property damage. The general liability insurance coverage must be obtained with combined single limits of $_____ (_____ Dollars) per occurrence and $_____ (_____ Dollars) aggregate per year, from an insurer with a Best's Rating of no less than A- or through a qualified self-insurer plan, implemented in accordance with Montana law and subject to the approval of the Department.

13.1.2 The School District, its officers, officials, agents, employees, and volunteers, are to be covered as additional insureds for liability arising out of activities performed by or on behalf of the Vendor, inclusive of the insured's general supervision of the Vendor, products and completed operations; and arising in relation to the premises owned, leased, occupied, or used by the Vendor.

THE RECOMMENDED COVERAGE FOR GENERAL LIABILITY INSURANCE IS $1,000,000 PER CLAIM AND $2,000,000 AGGREGATE PER YEAR. THE MINIMUM ALLOWABLE COVERAGE IS $_____ PER CLAIM AND $1,000,000 AGGREGATE PER YEAR. VARIATIONS MAY BE APPROVED BY THE BOARD OF TRUSTEES.

13.2 Automobile liability insurance.

13.2.1 Automobile insurance coverage is required when the Vendor is to transport student, when the transportation of students may occur as an activity related to the delivery of services or the delivery of services necessitates travel by Vendor or employees of the Vendor. Vendor's and School District's initials and date indicated automobile liability insurance is not required because Vendor will not transport students or travel as part of the performance of this contract.

	Initials	Date
Vendor	_____	_____
School District	_____	_____

13.2.2 If Section 13.2.1 is not initialed Vendor must provide proof of Automobile liability insurance and the following provision applies:

The Vendor must maintain, at its cost, automobile liability insurance coverage. The insurance must cover claims as may be caused by any act, omission, or negligence of the Vendor and/or its officers, agents, employees, representatives, assigns or subcontractors. The Vendor must provide automobile liability insurance inclusive of bodily injury, personal injury and property damage. The automobile liability insurance coverage must be obtained with combined single limits of $ _____ (_____Dollars) per occurrence and $ _____ (_____Dollars) aggregate per year, from an insurer with a Best's Rating of no less than A- or through a qualified self-insurer plan, implemented in accordance with Montana law and subject to the approval of the Department.

The School District, its officers, officials, agents, employees, and volunteers, are to be covered as additional insured for liability arising out of activities performed by or on behalf of the Vendor, inclusive of the Vendor's general supervision, or arising in relation to automobiles leased, hired, or borrowed by the Vendor.

THE RECOMMENDED AND MINIMUM COVERAGES ARE THE SAME AMOUNTS IDENTIFIED FOR GENERAL LIABILITY INSURANCE (SEE ABOVE).

13.3 Professional liability insurance. The Vendor must maintain, at its cost, professional liability insurance coverage against claims for harm to persons which may arise from the professional services provided

through this contract. The insurance must cover claims as may be caused by any act, omission, or negligence of the Vendor and/or its officers, agents, employees, representatives, assigns or subcontractors, assigns or employees.

13.3.1 The Vendor must provide occurrence coverage professional liability insurance with combined single limits of $ _____ (_____Dollars) per occurrence and $ _____ (_____Dollars) aggregate per year, from an insurer with a Best's Rating of no less than A-.

THE RECOMMENDED AND MINIMUM COVERAGES ARE THE SAME AMOUNTS IDENTIFIED FOR GENERAL LIABILITY INSURANCE (SEE ABOVE).

13.3.2 In lieu of occurrence coverage, the Vendor may provide claims made coverage with three years of additional tail coverage at the discretion of the Board of Trustees.

13.3.3 The Vendor must provide to the District a copy of the certificate of insurance showing compliance with the requisite coverage. All insurance required under this contract must remain in effect for the entire contract period. The Vendor must provide to the District copies of any new certificate or of any revisions to the existing certificate issued during the term of this contract. The District may require the Vendor to provide copies of any insurance policies pertinent to these requirements, any endorsements to those policies, and any subsequent modifications of those policies.

13.3.4 The Vendor's insurance coverage is the primary insurance in respect to the School District, its officers, officials, agents, employees, and volunteers. Any insurance or self-insurance maintained by the School District and its officers, officials, agents, employees, and volunteers is in excess of the Vendor's insurance and does not contribute with it.

13.3.5 Any deductible or self-insured retention must be declared to and approved by the District. At the request of the District, the insurer must:

13.3.5.1 Reduce or eliminate such deductibles or self-insured retentions in relation to the District, its officials, employees, and volunteers; or

13.3.5.2 The Vendor must procure a bond guaranteeing payment of losses and related investigations, claims administration, and defense expenses.

SECTION 14. COMPLIANCE WITH LOCAL, STATE AND FEDERAL ORDINANCES STATUTES, REGULATIONS, RULES, AND POLICIES.

14.1 Vendor agrees to comply with all federal, state and local statutes, regulations, ordinances and rules as well as any and all School District policies and procedures relating, directly or indirectly, to vendor's performance hereunder, including but not limited to all applicable laws pertaining to licensing, civil rights, equal employment opportunity, drug-free work place, the Health Insurance Portability and Accountability Act of 1996, PL 104-91 (HIPAA) and procurement integrity.

14.2 Vendor represents that it is not presently suspended or debarred by any government agency ore regulatory agency, proposed for suspension or debarment by any government agency or regulatory agency or otherwise excluded from participating in procurement activities funded with federal monies.

14.3 The Vendor agrees to ensure compliance of its subcontractors, if any, with the applicable federal requirements and assurances.

SECTION 15. COMPLIANCE WITH LABOR LAWS.

15.1 This Contract shall not constitute, create, or otherwise imply an employment, joint venture, partnership, agency or similar arrangement. Each Party to this Contract shall act as an independent contractor, and nei-

ther Party shall have the power to act for or bind the other Party except as expressly provided for herein.

15.2 Ineligible for Employee Benefits. Vendor and its employees shall not be eligible for any benefit available to employees of the School District, including, but not limited to, workers compensation insurance, state disability insurance, unemployment insurance, group health and life insurance, vacation pay, sick pay, severance pay, bonus plans, pension plans, savings plans and the like.

15.3 Payroll Taxes. No income, social security, state disability or other federal or state payroll tax will be deducted from payments made to Vendor under this Contract. Vendor agrees to pay all state and federal taxes and other levies and charges as they become due on account of monies paid to Vendor hereunder, and to defend, indemnify and hold School District harmless from and against any and all liability resulting from any failure to do so.

15.4 Workers' Compensation Insurance. The Vendor, at all times during the term of this contract, must maintain coverage for the Vendor and the Vendor's employees, if any, through workers' compensation, occupational disease, and any similar or related statutorily required insurance program. The Contractor must provide the School District with proof of necessary insurance coverage.

15.5 The Vendor is solely responsible for and must meet all labor, health, safety, and other legal requirements, including payment of all applicable taxes, premiums, deductions, withholdings, overtime and other amounts, which may be legally required with respect to the Vendor and any persons providing services on behalf of the Contractor under this contract.

15.6 The provision of this contract regarding indemnification applies with respect to any and all claims, obligations, liabilities, costs, attorney fees, losses or suits accruing or resulting from the Vendor's failure to comply with this section, or from any finding by any legal authority that any person providing services on behalf of the Vendor under this contract is an employee of the School District.

SECTION 16. LIAISONS.

16.1 The liaison for the School District is:

The liaison for the Vendor is:

These persons serve as the primary contacts between the Parties regarding the performance of this contract.

16.2 Written notices, reports and other information required to be exchanged between the Parties must be directed to the liaison at the parties' addresses set out in this contract.

SECTION 17. MISCELLANEOUS.

17.1 Attorneys' Fees. In the event suit is brought to enforce or interpret any part of this Contract, the prevailing Party shall be entitled to recover as an element of the costs of suit, and not as damages, reasonable attorneys' fees to be fixed by the Court.

17.2 Waiver, Modification and Amendment. No provision of this Contract may be waived unless in writing, signed by all of the parties hereto. Waiver of any one provision of this Contract shall not be deemed to be a continuing waiver or a waiver of any other provision. This Contract may be modified or amended only by a written contract executed by all of the parties hereto.

17.3 Governing Law; Venue. This Contract shall be governed and construed in accordance with the laws of the State of Montana, without regard to choice of law principles. The parties agree that the sole venue for legal actions related to this Contract shall be the state and U.S. Federal District courts in which the School District is located.

17.4 Assignment; Subcontracting. Neither this Contract nor any duties or obligations hereunder shall be assigned, transferred, or subcontracted by Vendor without the prior written approval of School District, which approval may be withheld in the sole and absolute discretion of School District.

17.5 Notices. All notices under this Contract will be in writing and will be delivered by personal service, facsimile or certified mail, postage prepaid, or overnight courier to such address as may be designated from time to time by the relevant Party, which initially shall be the address set forth on the signature page to this Contract. Any notice sent by certified mail will be deemed to have been given five (5) days after the date on which it is mailed. All other notices will be deemed given when received. No objection may be made to the manner of delivery of any notice actually received in writing by an authorized agent of a Party.

17.6 Partial Invalidity. If any provision of this Contract is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions shall nevertheless continue in full force without being impaired or invalidated in any manner.

17.7 Publicity. Neither Party shall make any public announcement concerning this Contract without the advance approval of the other Party. Notwithstanding the foregoing, if the parties are unable to agree on a mutually acceptable announcement, a Party may nevertheless issue a press release if it is advised by counsel that such release is necessary to comply with applicable securities or similar laws.

17.8 Waiver of any default, breach or failure to perform under this contract is not deemed to be a waiver of any subsequent default, breach or failure of performance. In addition, waiver of any default, breach or failure to perform is not construed to be a modification of the terms of this contract unless reduced to writing as an amendment to this contract.

SECTION 18. ENTIRE CONTRACT. This Contract contains the entire agreement and understanding of the parties with respect to the subject matter hereof, and supersedes and replaces any and all prior discussions, representations and understandings, whether oral or written. The Parties through their authorized agents have executed this contract on the dates set out below.

SCHOOL DISTRICT

By: _____ Date _____
_____ as _____
Typed/Printed Name Title

VENDOR

By: _____ Date _____
_____ as _____
Typed/Printed Name Title

_____
_____
Address

_____
Phone Number

Exhibit 1
Statement of Work

The Vendor will provide the School District with the following services:

1. Meet all CSCT program staffing requirements as required by the Department of Public Health and Human Services;
2. Ensure all children within the school or the school district, as appropriate, who meet the described criteria for service are considered for admission to the program;
3. Provide a program of services staffed by at least 2 mental health workers who work exclusively in the school;
4. Ensure that at least 1 of the 2 mental health workers are a licensed psychologist, licensed clinical social worker, or licensed professional counselor.
5. The CSCT team may provide up to 720 units of service per calendar month;
6. Develop and implement a CSCT plan of care in cooperation with the District for each enrolled child;
7. Provide treatment, crisis management and discharge planning services to enrolled children;
8. Provide regular updates of a child's plan of care to the District and pertinent agencies;
9. Provide for family involvement in treatment and discharge planning and in the course of treatment;
10. Provide continuing contact and information exchange with persons and agencies significantly involved in the child's treatment;
11. Provide the School District with the necessary support documentation to enable School District to bill Medicaid for services provided to Medicaid eligible children;
12. Ensure that all available financial resources for support of services including third party insurance and parent payment are utilized;
13. Bill for all third parties for services provided to non-Medicaid eligible children including family members; and
14. Ensure that services delivered are adequately documented to support the reimbursement received.

Exhibit 2
Payment Schedule

School District will reimburse Vendor according to the following payment schedule:

For Medicaid eligible children receiving Medicaid covered CSCT services, $ _____dollars per day/week/month for CSCT services rendered.

It will be the responsibility of the Vendor to recoup payment for CSCT services rendered to Non-Medicaid eligible children from all third party payers following the Department of Public Health and Human Services third party liability guidelines. For children that do not have third party insurance coverage, the Vendor agrees to bill the student or student's family following the Department of Public Health and Human Services sliding fee schedule for CSCT services provided to Non-Medicaid eligible, uninsured students.